



BON SECOURS MEDICAL GROUP

PATIENT HISTORY

Name _____ Age _____ Date _____

Referring Physician _____

Name of Primary Care Physician _____

PRESENT ILLNESS

What is the reason for your visit today?

Date of last mammogram _____ Location _____

List all members of your family who have had breast or ovarian cancer. _____ None

MEDICATIONS

_____ None

Name _____ Dosage _____ # of times per day _____

ALLERGIES

_____ None

Substance _____ Effect _____

PAST MEDICAL HISTORY

PAST SURGERY (operations) _____ None

Date _____ Operation _____ Hospital/Doctor _____

REVIEW OF SYSTEMS

Do you currently have any of these symptoms? Check all that apply

CONSTITUTIONAL

weight gain loss of appetite fever
 night sweats weight loss fatigue

EARS, EYES, NOSE, THROAT

sore throat nose bleed difficulty swallowing
 dizziness cataracts bleeding gums

NEUROLOGIC

insomnia memory loss fainting
 weakness on one side tremors headache
 slurred speech temporary blindness

RESPIRATORY

pain with breathing cough coughing blood

CARDIOVASCULAR

chest pain swelling in feet/ankles shortness of breath
 leg pain when walking irregular heart beat

GASTROINTESTINAL

nausea/vomiting heartburn black/bloody stool
 abdominal pain diarrhea constipation

GENITOURINARY

blood in urine frequent urination
 urinary incontinence urinating at night

MUSCULOSKELETAL

joint swelling joint pain joint stiffness
 back trouble muscle pain bone pain

SKIN

rash lumps lymphedema itching

PSYCHIATRIC

high stress anxiety drug/alcohol abuse

ENDOCRINE

excessive sweating excessive thirst excessive urination
 feeling too hot feeling too cold

HEMATOLOGIC/LYMPHATIC

easy bruising bleeding disorders blood clots
 immune deficiency

FEMALE REPRODUCTIVE

heavy periods frequent yeast infection bleeding btwn periods
 postmenopausal bleeding irregular periods
 breast pain with periods hot flashes

GYN HISTORY

Age when period started _____ stopped _____

Age when first child was born _____

Did you breastfeed? Yes / No

Are you breastfeeding at this time? Yes / No

Could you be pregnant? Yes / No Last menstrual period _____

of pregnancies _____ # of deliveries _____ # of miscarriages/abortions _____

Have you had a hysterectomy? Yes / No Ovaries removed Yes / No

Have you taken birth control pills? Yes / No From _____ to _____

Method of birth control _____

Have you taken estrogen? Yes / No From _____ to _____

Have you had any prior breast biopsies? Yes / No Right _____ When _____
Left _____ When _____

SOCIAL HISTORY

Caffeine _____ drinks / day

Alcohol _____ drinks / week

Cigarettes _____ packs / day

FAMILY HISTORY Alive/Age Deceased/Age Medical Problems

Mother _____

Father _____

Sisters _____

Brothers _____

Daughters _____

Sons _____

Signature _____ Date _____